Vitality Pediatric Healthcare.

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Intake and Referral Form

Date of Referral: _____ Caller's Name: _____ Phone Number: _____
Affiliation to Patient: _____ Requested Start Date: _____
Hospital (I applicable): _____ Anticipated DC: _____

Patient Name: _____ Phone Number: _____
DOB: _____ Sex: M or F Diagnosis: _____ ☐ Trach ☐ Vent
Address: _____
Caregiver Name: _____ Phone Number: _____
Skilled Needs: _____

Physician order: Evaluate or Evaluate & Treat or Currently Receiving

Type of Service	Requested Hours per Week	Requested Visits per Week
RN / LVN PDN		
HHA		
RN /LVN Visits		

Physician Name: _____ Phone / Fax: _____
Address: _____
Referral Source: _____
Are Nursing Service Currently Being Provided: ☐ Yes, ☐ No Current Agency: _____
Are MDCP Services being provided: ☐ Yes ☐ No Current Agency: _____ # of Hours: _____
Is Case Manager Assigned: ☐ Yes ☐ No Name: _____ Phone: _____

Primary Payor Source:
☐ Private Pay ☐ Private Insurance ☐ Medicaid Type: _____ ☐ Other Trust Fund ☐ Yes ☐ No
If Medicaid: Policy #: _____ Verified ☐ Yes ☐ No (Please Attach)

If Insurance: Name of Insurance Provider: _____ Customer Svc #: _____
Policy #: _____ Group #: _____ Group Name: _____
Policy Holder's Name: _____ **DOB:** _____ **SS#:** _____
Relationship to Patient (If not Self): _____

Secondary Payor Source:
☐ Private Pay ☐ Private Insurance ☐ Medicaid Type: _____ ☐ Other Trust Fund ☐ Yes ☐ No
If Medicaid: Policy #: _____ Verified ☐ Yes ☐ No (Please Attach)

If Insurance: Name of Insurance Provider: _____ Customer Svc #: _____
Policy #: _____ Group #: _____ Group Name: _____
Policy Holder's Name: _____ **DOB**: _____ **SS#:** _____
Relationship to Patient (If not Self): _____

Intake Coordinator: _____ Date: _____
Benefits Verified: ☐ Yes ☐ No Signature: _____ Date: _____
Entered In SAM: ☐ Yes ☐ No Signature:_____Date:_____